Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NIX HEALTH CARE SYSTEM
210 S. FLORIDA AVE
LAKELAND FL 33801

Respondent Name
AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box
Number 19

MFDR Tracking Number
M4-12-3553-01

MFDR Date Received
August 10, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are working with Nix Health Care System...We have determined…the account for this patient was reimbursed incorrectly…the expected reimbursement on this bill is to be calculated as follows:

CPT 97110 per Trailblazer $28.74*200%=$57.48* 20 units= $1149.60
HCPCS G0283 per Trailblazer $12.20*200%=$24.40
For total expected reimbursement due of $1174.00, creating an underpayment of $231.82."

Amount in Dispute: $231.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable…"

Response submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 4 through 26, 2011 October 21, 2011	97110: 54.54 ÷ 33.9764 x $28.74 x 1 unit = $46.13 x 20 units = $922.60 G0283: : 54.54 ÷ 33.9764 x $12.20 x 1 unit = $19.58	$231.82	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.403 applies to medical services provided in an outpatient acute care hospital on or after March 1, 2008.
3. 28 Texas Administrative Code §134.203 sets forth the fee reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanations of benefits
   - W1 – workers compensation jurisdictional fee schedule adjustment
   - 356 – this outpatient allowance was based on the Medicare's methodology (part B) plus the Texas markup

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Division rule at 28 Texas Administrative Code §134.403(h) states that for medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided, §134.203(c).

2. According to 28 Texas Administrative Code §134.203 (c)(1), services performed at a facility that per Medicare default to Part B including physical, occupational, and speech therapy performed in a hospital on an outpatient bases are calculated as follows:

   Code 97110: 54.54 Workers Compensation conversion factor ÷ 33.9764 Medicare conversion factor x $28.74 Participating Amount x 1 unit = $46.13 x 20 units = $922.60.

   Code G0283: 54.54 Workers Compensation conversion factor ÷ 33.9764 Medicare conversion factor x $12.20 Participating Amount x 1 unit = $19.58. Total due for both codes = $942.18. The insurance carrier paid $942.18. No additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services involved in this dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution	March , 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.